Project to Improve Independent Medical Examinations
For the State of Washington
Department of Labor and Industries

Chapter 2

Problem Statement

Downloadable Version, Part 5 of 6

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IME Report Audit

Introduction

The Stakeholder Interview section of this report referenced use of the audit of IME reports to test four expectations:

1. The IME accurately and completely answers the questions asked by the claims examiner, (Expectation #1, p.31)
2. A streamlined, reliable and consistent process exists for administering and obtaining high quality IMEs, (Expectation #2, p.32)
3. IMEs are consistent with the Department of Labor and Industries (L&I) rules, guidance and regulations, (Expectation #5, p.33)
4. A qualified, competent and credible pool of examiners performs IMEs, (Expectation #6, p.33)

   Qualifications and competence are inferred from the work product (the report). Credibility is a matter of coherent and well-explained logic in reaching conclusions and rating impairments. It implies adherence to the evidence base for accurate diagnosis, causal attribution, appropriateness and effectiveness of treatment, and time to recovery. The explanation should be complete.

Expectations 3 and 4 concerning injured worker dignity and APs finding the IMEs useful were addressed in the previous two sections.

The audit compares the attributes of this statistically valid sample of reports to the major attributes that users of the IME reports seek.

Methodology

A group of six medical and two chiropractic physicians with extensive experience in occupational medicine, rehabilitation and orthopedics constructed an audit tool based on

the best practices in IMEs as reported in the literature and those taught in national IME courses. The tool was subjected to several review cycles internally and with L&I. It covers some time cycles, declarations and information given to the examinee, records review, history and physical examination elements, and various analyses. Other factors considered in structuring the audit tool included the utility to the intended audience. Utility was dictated by the detail and type of explanation needed, the minimum objective data required, and having the necessary analysis and interpretation. Another issue was the timing of the requested information in the context of the progress of the case, its history and the presence of a dispute. The audit tool is included in the accompanying Appendix 6.

Sample Selection

The audit sample was comprised of the medical records of the respondents to the survey of injured workers, including the IME reports. The survey of injured workers (IW's) was drawn from a sample frame provided by L&I of 32,816 claims with an IME payment code in calendar year 2000. The payment codes did not necessarily indicate that the IME exam occurred in CY 2000, merely that payment did occur in that time frame. The claims had a unique person id that allowed us to identify IW's with multiple claims.

Each claim was assigned to a diagnostic grouping based on the first reported ICD9CM code. The sample was restricted to those IW's with low back soft tissue problems, shoulder soft tissue problems and carpal tunnel syndrome, which is an occupational disease. There were 7804 claimants in those categories. These claimants were further broken down into two claim complexity categories (low, high) , based on the payment code for their last IME in CY 2000.

About 26% of the claimants were classified as having a low complexity IME; 74% had a more complex IME or multiple examiners.

A random sample of 750 claimants was drawn equally from each injury category. The sample size was determined by budgetary and time constraints. The sampling mechanism was designed to ensure that the sample was representative of the sample time frame.

Within each category, the sample was drawn proportional to the overall population rate of high complexity versus low complexity exams (as defined for the purposes of this survey).

Of the 750 claims, 684 were found to have a CY2000 payment code indicating that an IME occurred in that year. (These were the codes for an IME not an exam conducted by the attending physician). Those without a valid CY 2000 payment code were excluded from the survey.

A small percentage of the claimants reported during the survey process that the IME examiner was actually their attending physician. Those claims should have been excluded from the sample and their results were excluded in the preceding analysis.

The overall survey had a 41% response rate or 278 valid respondents. The IME documents from department microfiche were provided to the physician auditor panel that evaluated 135 factors on each IME. One factor was whether the condition being evaluated by the IME was the same as the sampling diagnostic grouping. For 218 of the 278 claims (78.4%), it was the same. The 60 non-matching IMEs were excluded from the audit analysis. These claims were either ones with multiple diagnoses or ones where the initial diagnosis was refined over time.

Audit Process

The physician group used the audit tool to conduct a three-step audit process assessing the request letters, questions and summaries submitted to the examiner and the reports of the independent medical examinations.

1. The information requested was determined, both from the stated purpose of the IME and from the questions asked.
2. The documentation in the IME report was assessed. In the record review, we looked for inclusion of primary data (symptoms, signs, test results), as well as a direct review of imaging tests. In the IME examiner's interview with the claimant, we looked for completeness of questioning, and proper and complete documentation. In the report of the physical examination, we looked for inclusion of necessary findings (positive and negative).
3. Finally, we assessed the analysis of the above data and the explanation of the examiner's basis for his or her opinion. Areas analyzed include previous diagnoses, causality attribution, medical necessity, and adequacy of treatment, with identification of inconsistencies in the prior records.

In assessing the opinions presented, we asked:

- Do the facts cited in the analysis support the opinion?
- Is there explicit analysis explaining the basis for the opinion?
- Is the analysis consistent with medical science?

In the answers to the questions posed, we looked for clearly explained logic and consistency with guidelines or scientific evidence.

There were several constraints limiting this audit. First, we reviewed only the IME report and request letters, not the full claim file. Thus, there was no independent verification of the facts presented in the report. In addition, there was no link with the claim process or its outcomes.

Summary Findings

Independent Medical Examinations paid for in calendar year 2000 by the Washington State Department of Labor and Industries were variable in form, content, and level of detail. Form varied among IME brokers and to a lesser degree within each broker company. The level of detail presented was quite variable, ranging from complete and clear to fragmented and summary. The level of analysis presented ranged from non-existent to excellent, with the majority of analyses being cursory. In a substantial number of cases, the opinions in the IME reports examined in the audit were not supported by the evidence base and guidelines available.

The format and areas covered in the IME reports audited appear to be uniform within each IME broker. To a substantial degree, this appears to be the result of the repetitive use of a set of broad, standard questions for IMEs requested for any issue. When the same broad questions are asked, the reports tend to look similar.

IMEs obtained in Washington can be improved by presenting a *well-reasoned* opinion based on a demonstrated understanding of the key facts and evidence in a case. Scientific evidence and guidelines were in fact rarely cited, and analysis and decision logic were lacking or incomplete. In many cases, it appears that the examiners simply accepted prior opinions. This lack of reference to facts and analysis renders the reports less than optimally useful in legal dispute resolution, and in furthering the understanding of the case for care and disability management.

The weakest areas of the reports, as a group, were the history of the case, and analyses, particularly analyses of causation, previous care and disability management, and the overall course of the case. Explanations of the logic for recommendations, ratings and conclusions were also weak or missing. Explanation of ratings was quite variable, typically not referencing specific criteria. Shoulder ratings were generally explained, however several of these ratings were erroneous. Low back soft tissue complaints and hand and wrist nerve compression were more often than not hard to understand and

questionable. What was lacking, then, was an organized, systematic summary of the case history from prior records, an independent causation assessment, a critical assessment of the adequacy of previous care, and, for any required topic, an explicit analysis based on cited facts.

In comparing the reports as a group to customer (typically claim manager) expectations (previously outlined in the Stakeholder Interview section, page 23), we noted the following:

- *The IME accurately and completely answers the questions asked* (Expectation #1, p.31)

  There seemed to be less than full satisfaction of the informational needs of the claim manager in many of the IME reports reviewed. There were very few clear explanations of the logic used to arrive at causation, diagnoses, appropriate treatment plans, maximal medical improvement.

  In at least three important areas, the sample of IME reports reviewed was inconsistent with criteria for excellent IMEs. The first area was causality logic. Causation is an issue for any new claim, for newly contended conditions, in assessing medical indications for re-opening claims, and for identifying the relatedness of complications. Correct attribution of causation is important both for work relatedness and for apportionment. As outlined in the next section, reports did not typically meet criteria.

  Secondly, past and recommended treatment plans should be consistent with evidence for appropriateness and effectiveness, usually found in clinical practice guidelines or meta-analyses. Retrospectively, the examiner is expected to review previous treatment plans. Prospectively, the examiner may be asked to review recommendations for further treatment, or to make such recommendations. Again, there was rarely a critical analysis evident.

Thirdly, in order to assess whether the claimant has achieved maximal medical improvement and is fixed and stable, the examiner would be expected to assess functional abilities. Areas of function include general abilities and function, activities of daily living, and work abilities compared to job requirements. The reports did not adequately define functional abilities.

- *A streamlined, reliable and consistent process exists for administering and obtaining high quality IMEs* (Expectation #2, p. 32)

  The process of requesting an IME from schedulers, and of notifying the examinee appeared consistent from the documentation presented. The request letters demonstrated consistency in using the same group of standard questions. However, the questions were not focused on specific case issues for the most part. Time intervals appeared to be reasonable and consistent, with some exceptions. Schedulers consistently used IME broker companies. The process for selecting the IME broker companies was not clear from this audit, however. There did not appear to be a systematic quality management process in place at the IME broker companies.

- *IMEs are consistent with L&I rules, guidance and regulations* (Expectation #5, p.33)

  We observed that the reports generally followed L&I guidance in the *Medical Examiners' Handbook* and the relevant WACs. However, L&I guidance about format, required data elements, and logic and analysis could be more explicit and detailed.

  In order to be credible, and therefore useful in the legal process, an IME report must present clear statements of facts, comparative evidence, and logic. As discussed in the Detailed Audit Results beginning on page 84, several of the greatest deficiencies in the IME reports reviewed were the dearth of reference to

scientific evidence or guidelines, and clear explications of logic for a variety of conclusions.

- *A qualified, competent and credible pool of examiners performs IMEs* (Expectation #6, p.33)

Our inference from this IME report audit is that while examiners appear to be competent physical examiners in general, and appear impartial, they have not acquired the specialized skills needed to prepare an excellent IME report. Further, at least one auditor felt that they took the path of least resistance by simply accepting prior diagnoses and conclusions. One physician-reviewer observed, "Physicians who stated they were credentialed in the performance of these evaluations, either as a Certified Independent Medical Examiner (American Board of Independent Medical Examiners) or a Fellow of the American Academy of Disability Evaluating Physicians, performed only a few of the evaluations." The number so certified was not sufficient to demonstrate whether quality was significantly different between those certified and those not certified.

Reviewers consistently noted that the explanation of the logic and basis for opinions rendered in the reports were rarely present. This has a significant impact on the usability of the IME report to the claim manager and personnel without medical training. This also may affect an examiner's credibility if he or she is later called to testify in legal proceedings.